130 CMR 521.000will be repealed effective January 1, 2014.

~~TABLE OF CONTENTS~~

~~Section~~

521.001: Introduction

130 CMR 521.000 contains related program benefits that a MassHealth member may receive. These services include reimbursement of certain out-of-pocket medical expenses, and enrollment in a group health insurance plan when MassHealth determines it is cost effective.

521.002: Reserved

521.003: MassHealth Standard/CommonHealth Premium Assistance (MSCPA)

MassHealth pays for the cost of enrolling an eligible MassHealth Standard member who has access to employer-based group insurance when MassHealth determines it is cost effective to do so and the insurance meets the basic benefit level as described at 130 CMR 501.001.

(A) Period of Eligibility. MassHealth continues to pay the health insurance premiums as long as the health insurance plan continues to be cost effective and meets the basic benefit level as described at 130 CMR 501.001.

(B) Method of Premium Payment. Monthly payments of health insurance premiums are made directly to the policyholder, as determined by MassHealth. Proof of health insurance premium payments may be required from the parent or member. Premium assistance payments begin in the month of MassHealth's eligibility determination for MSCPA or in the month the health insurance deduction begins, whichever is later. Each monthly payment is for coverage in the following month.

(C) Review of Cost Effectiveness and Basic Benefit Level Requirement. MassHealth reviews the cost effectiveness of each case at least once every 12 months for health insurance plans. In addition, reviews of the cost effectiveness are completed by MassHealth whenever the cost of the group health insurance plan changes, when any individuals under the policy are no longer eligible for MassHealth, or when there is a change in the services covered under the policy that affects the basic benefit level requirements.

(D) Time Frames for Determining Cost Effectiveness and Basic Benefit Level Requirement. MassHealth determines the cost effectiveness of the insurance plan and notifies the member of the decision regarding payment of the premiums within 60 days of the date MassHealth is notified of a request to enroll in MSCPA. Additional time may be granted when, for reasons beyond the control of MassHealth or the member, information needed to establish cost effectiveness or the basic benefit level cannot be obtained within the 60-day period.

(E) Conditions of Eligibility. The member, or a person acting on the member's behalf, must cooperate in providing information necessary for MassHealth to determine the availability and cost effectiveness of group health insurance. Individuals who are eligible to enroll in a group health insurance plan that MassHealth has determined to be cost effective, and who are otherwise eligible for MassHealth Standard, must apply for enrollment and continue to be enrolled in the plan as a condition of MassHealth eligibility.

(F) Failure to Cooperate. The eligibility of a child or spouse for MassHealth is not affected by the parent's or spouse's failure to cooperate.

521.004: Reimbursement of Certain Out-of-Pocket Medical Expenses

(A) Eligibility Requirements. The following Standard coverage members are entitled to reimbursement for certain medical expenses for which they paid, subject to the provisions of 130 CMR 521.004.

(1) An individual who:

(a) applied for Supplemental Security Income (SSI);

(b) was denied SSI benefits by the Social Security Administration; and

(c) had his or her initial Social Security Administration denial overturned through a reconsideration process, administrative hearing, appeals counsel review, federal court review, or reopening under the Social Security Administration rules on administrative finality.

(2) An individual who:

(a) applied for MassHealth;

(b) was denied MassHealth; and

(c) had his or her initial denial overturned by a subsequent decision, MassHealth, the fair hearing process, or the judicial review process.

(B) Limitations.

(1) Reimbursement is limited to bills incurred on or after the date of initial MassHealth eligibility, and paid between the date of the erroneous eligibility decision and the date on which the member is notified of MassHealth eligibility. The bill must have been paid by the member, the member's spouse, the parent of a member, or a legal guardian.

(2) Reimbursement is also limited to amounts actually paid for care or services that would have been covered under MassHealth had eligibility been determined correctly, even if these amounts exceed the MassHealth rate. Before reimbursing a member for care or services that would have required prior authorization, MassHealth may require submission of medical evidence for consideration under the prior-authorization standards. Reimbursement is available even though the medical care or services were furnished by a provider who does not participate in MassHealth.

(C) Verification.

(1) Applicants or members seeking reimbursement must provide MassHealth with:

(a) a bill for medical services that includes:

(i) the provider's name;

(ii) a description of the services provided; and

(iii) the date the service was provided; and

(b) proof of payment of the bill presented, such as a canceled check or receipt.

(2) Recipients of SSI must also provide documents from the Social Security Administration establishing the date of application and the date of application denial.